



BAPTIST HEALTH SOUTH FLORIDA

Patient Name: [REDACTED]

11/9/2018

Parker, Jeannette M. [REDACTED]

Due Date:

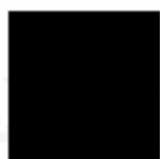
Upon Receipt

REQUEST FOR PAYMENT

Account Summary

Date of Service: 9/22/2018
 Description of Service: Emergency Department
 Place of Service: Mariners Hospital
 Total Charges \$ 48,512.00
 Insurance Payments / Adjustments - \$ 44,320.90
 Prior Patient Payments \$ 0.00
AMOUNT YOU OWE **\$ 4,191.10**

Pay online! It's fast, easy, and secure.
<https://billpay.baptisthealth.net>



Scan this code to pay with your smart phone.



Our automated system provides up-to-date information about your account 24/7 at 786-596-6507 or toll free at 1-800-235-0065.



See reverse side of this statement for frequently asked questions.

IMPORTANT MESSAGE

We previously notified you that the balance due is your responsibility. Our records indicate that we have not received payment for the account balance. We are requesting that you please pay the amount due immediately. If we do not receive your payment within 15 days we will consider your account past due. Pay online securely at: <https://billpay.baptisthealth.net>.

If you have any questions about your out-of-pocket expense, please contact your insurance provider so that they can explain how your claim was processed. Your insurance provider determines benefit coverage, and any patient financial responsibility. Our Baptist Health Customer Service Representatives do not have access to the terms of your insurance policy.

Statement 63

Pay By Mail for Account Number: [REDACTED]

Amount Due	Due Date	Amount Enclosed
\$ 4,191.10	Upon Receipt	\$ _____



BAPTIST HEALTH SOUTH FLORIDA
 PO Box 830880
 Miami, FL 33283

Parker, Jeannette M. [REDACTED]

Mail Payment Here

Mariners Hospital
 PO Box 198116
 Atlanta, GA 30384-8116



Mariners Hospital
P O Box 198116
Atlanta, GA 303848116

Pt Name: Jeannette M Parker
Attending Physician: [REDACTED]
Provider: Mariners Hosp
Provider Tax ID #: [REDACTED]
Bill Date: 12/20/2018

ECD:
ENC:
Statement Number:
Account Number:
Claim ID: [REDACTED]

Detail for: [REDACTED]

<u>Date</u>	<u>Svc Cd</u>	<u>Description</u>	<u>Qty</u>	<u>Amount (\$)</u>
Charges				
09/22/2018	36603322	Immun admin ea add vacc toxinj	1	143.00
09/22/2018	49087547	Vacc boostrix 0.5 ml inj	1	112.00
09/22/2018	49003205	Augmentin 875mg tab	1	2.00
09/22/2018	36603314	Immun admin 1st vacc tox inj	1	143.00
09/22/2018	49011281	Vacc rabies 2.5u vial	1	968.00
09/22/2018	49033673	Imm glob rabies 2ml inj	6	46,422.00
09/22/2018	36600153	Level II	1	722.00

Payments/Adjustments

10/19/2018 Cigna Insurance Payment -34,618.50

The charges in this statement are a facility fee. A facility fee is intended to offset the operational and administrative costs of a facility and may include, without limitation, costs associated with nursing care, critical care, ancillary services, anesthesia, equipment, operating rooms, recovery rooms, supplies, medications, room and board, and other personnel and staff. Facility-based physicians and other health care providers who rendered services to the patient may bill separately. A list of such physicians and providers is available at <http://BaptistHealth.net/AffiliatedPractices>. Please contact the patient's insurer or HMO regarding any cost-sharing responsibilities.

Baptist Health South Florida
P O Box 830880
Miami FL 33283

Financial Coverages

Our record indicate the following insurance plans. Please call us as soon as possible with any changes or additions at (786) 596-6507 or 1 (800) 235-0065.

<u>Priority</u>	<u>Plan Name</u>	<u>Policy #</u>	<u>Subscriber</u>
1	Cigna Open Access Plus	[REDACTED]	[REDACTED]

ADDRESS SERVICE REQUESTED

JEANNETTE M. PARKER

Guarantor: Jeannette M. Parker


[Back to claim search](#)

Claim Detail: Claim ID - [REDACTED]

Patient

Name: JEANNETTE PARKER
 Address: [REDACTED]
 Member ID: [REDACTED]

Provider

Name (NPI): MARINERS HOSPITAL (1518941806)
 Address: PO BOX 198193
 ATLANTA, GA 30384

Network Indicator: In Network

Claim Totals

Charges:	\$48,512.00
Not Covered:	\$9,680.00
Paid To:	MARINERS HOSPITAL
Check Number:	[REDACTED]
Plan Pays:	\$34,618.50
Deductibles:	\$344.60
Co-pay:	\$0.00
Co-insurance:	\$3,846.50
Other Insurance Paid:	\$0.00
Member Resp.:	\$4,191.10

$\$38,809.60 \times 10\% = \3880.96
~~Ded. 344.60~~
 $\$4225.56?$

Service Date	REV Code	Charge	Allowed	Other				Reason Code
				Ins Paid	Not Covered	Member Resp.	Plan Paid	
09/22/2018	0250	\$2.00	\$1.60	\$0.00	\$0.40	\$1.60	\$0.00	
09/22/2018	0450	\$722.00	\$577.60	\$0.00	\$144.40	\$366.46	\$211.14	
09/22/2018	0636	\$968.00	\$774.40	\$0.00	\$193.60	\$77.44	\$696.96	
09/22/2018	0636	\$46,422.00	\$37,137.60	\$0.00	\$9,284.40	\$3,713.76	\$33,423.84	
09/22/2018	0636	\$112.00	\$89.60	\$0.00	\$0.00	\$8.96	\$80.64	
Grand Total:		\$48,512.00	\$38,809.60	\$0.00	\$9,680.00	\$4,191.10	\$34,618.50	

Service Date	REV Code	Charge	Allowed	Other					Reason Code
				Ins Paid	Not Covered	Member Resp.	Plan Paid		
09/22/2018	0771	\$143.00	\$114.40	\$0.00	\$28.60	\$11.44	\$102.96		
09/22/2018	0771	\$143.00	\$114.40	\$0.00	\$28.60	\$11.44	\$102.96		
Grand Total:		\$48,512.00	\$38,809.60	\$0.00	\$9,680.00	\$4,191.10	\$34,618.50		

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